STATEMENT OF PERSONAL INJURY – POSSIBLE THIRD PARTY LIABILITY

Persons that cause injuries to active, retired, or separated US Army personnel and/or their family members with medical benefits, may be liable for medical care costs and services.

PRINCIPAL PURPOSE: To assist in determining possible third party liability for medical supplies and services. Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States. *ALL MONIES* collected under the medical care recovery program are forwarded to Fox Health Center and Tricare to help fund continued patient care.

STATEMENT OF INCIDENT

QUESTIONNAIRE

INSTRUCTIONS FOR COMPLETION OF QUESTIONNAIRE

You must provide all information that pertains to the circumstances of your injury. For sections that do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. The attached law, Title 32 Code of Federal Regulations, Section 220.9, which requires completion of this form applies equally to active, retired, or separated United States Army personnel and/or their family members. If you are represented by an attorney, refer this questionnaire to your attorney for assistance.

* * * **RETURN COMPLETED QUESTIONNAIRE TO:** * * *

DEPARTMENT OF THE ARMY, OFFICE OF THE STAFF JUDGE ADVOCATE ATTN: AMSAM L J C 111 GOSS ROAD REDSTONE ARSENAL, ALABAMA 35898-5120

INJURED PARTY

NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY #
HOME ADDRESS	**HOME TELEPHONE**	**WORK TELEPHONE**

MILITARY SPONSOR

BRANCH OF SERVICE						SPONSOR'S STATUS				
(Check One):	USA ☐	USAF ☐	USN ☐	USMC ☐	OTHER ☐	(Check One):	Active Duty ☐	Retired ☐	ETS'd ☐	Deceased ☐

NAME (Last, First, MI)	GRADE/RANK	SPONSOR'S SSN
MILITARY UNIT MAILING ADDRESS (If sponsor is on active duty)		**UNIT TELEPHONE**

DETAILS OF THE INCIDENT

DATE	TIME AM ☐ PM ☐	COUNTY
STREET	CITY	STATE
POLICE AGENCY INVESTIGATION ?:	YES ☐ NO ☐	MILITARY ☐ CIVILIAN ☐
IF YES, NAME OF AGENCY	TRAFFIC ACCIDENT REPORT #	ACCIDENT REPORT ATTACHED? YES ☐ NO ☐
WAS A CITATION ISSUED? YES ☐ NO ☐	IF YES, TO WHOM	CITED FOR

IN YOUR OWN WORDS, *please describe below*: (1) The circumstances of exactly *how* the incident occurred, (2) How *you* came to be injured, and (3) *Who* (if anyone) was at fault. (Please PRINT)

MOTOR VEHICLE ACCIDENTS

IMPORTANT: Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the Office of the Staff Judge Advocate.

I WAS A:	DRIVER ☐	PASSENGER ☐	PEDESTRIAN ☐	BICYCLIST ☐	OTHER ☐

YOUR VEHICLE	YEAR	MAKE	MODEL

NAME OF DRIVER	ADDRESS
NAME OF OWNER (if different than driver)	ADDRESS
INSURANCE COMPANY	ADDRESS

IS A COPY OF THE AUTO POLICY ATTACHED ? :		YES ☐	NO ☐
TYPES OF POLICY COVERAGE: Check (3) all types that apply and indicate coverage amounts:	☐ Personal Injury Protection (PIP) Coverage Amount $	☐ Medical Payments (MedPay) Coverage Amount $	☐ Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount $

THE *OTHER* VEHICLE	YEAR	MAKE	MODEL

NAME OF *OTHER* DRIVER	ADDRESS
NAME OF *OTHER* VEHICLE'S OWNER	ADDRESS
OTHER DRIVER'S INSURANCE COMPANY	ADDRESS

WORKER'S COMPENSATION CLAIM

NAME OF BUSINESS/ORGANIZATION	ADDRESS
EMPLOYER'S INSURANCE COMPANY	ADDRESS
NAME OF CLAIMS ADJUSTER	CLAIMS ADJUSTER'S TELEPHONE NUMBER
WORKER'S COMPENSATION CLAIM NUMBER:	OTHER INFORMATION:

OTHER TYPES OF INCIDENTS

INJURY OCCURRED AT:	MY HOME ☐	OTHER RESIDENCE ☐	SCHOOL ☐	PUBLIC PROPERTY ☐	PRIVATE PROPERTY ☐

NAME OF PROPERTY OWNER	ADDRESS
NAME OF INSURANCE COMPANY	ADDRESS
NAME OF CLAIM ADJUSTER	CLAIM ADJUSTER'S TELEPHONE NUMBER
INSURANCE POLICY NUMBER:	INSURANCE CLAIM NUMBER:

MEDICAL CONDITION

DESCRIBE BELOW WHAT INJURY or INJURIES WERE EVALUATED OR TREATED AS A RESULT OF THIS INCIDENT:

(Please *be specific* when describing the nature and severity of your illness/injuries, being careful to include "Left" or "Right", when specifying bodily location. Also indicate if any surgeries or tests have been performed or *will be* performed).

LIST BELOW THE NAMES OF MILITARY FACILITIES PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

MILITARY MEDICAL FACILITY(IES):

Other Military Facility
(Please specify) :

LIST BELOW THE NAMES OF CIVILIAN FACILITIES PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

NON-MILITARY MEDICAL FACILITY(IES):
(or Doctor's Name)

HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID? NO ☐ YES ☐ (IF "*Yes*," please specify by whom) :	ME ☐	ARMY ☐	CHAMPUS ☐ (TRICARE)	INSURANCE ☐	ATTORNEY ☐	OTHER ☐

MISCELLANEOUS INFORMATION (Required)			PLEASE SPECIFY:
Do you *handcarry* your medical record?	YES ☐	NO ☐	Where kept:
Are you still receiving treatment ?	YES ☐	NO ☐	If yes, Where:
Have you signed any release form ?	YES ☐	NO ☐	From Whom:
Has property damage been paid ?	YES ☐	NO ☐	By Whom:
Has personal injury been paid ?	YES ☐	NO ☐	By Whom:
Did you miss any duty days ? (*)	YES ☐	NO ☐	List Dates:

(*) **NOTE:** *Active Duty* soldiers who missed complete duty days -MUST- submit a copy of their Leave and Earning Statement (LES) -and- complete a "CERTIFICATION STATEMENT of Military Services Due to Third Party Incident" (attached).

ATTORNEY REPRESENTATION

NAME OF LAW FIRM	ADDRESS
ATTORNEY'S NAME	ATTORNEY'S TELEPHONE NUMBER/FAX NUMBER

CHECK THIS BOX: IF YOU HAVE -NOT- RETAINED THE SERVICES OF AN ATTORNEY RELATIVE TO THIS INCIDENT: ☐

INJURED PARTY'S STATEMENT AND SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE FORGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I hereby acknowledge receipt of the "*Advice to Injured Party*" form and understand that use of this information is authorized by law in pursing claims in favor of the U.S. Government.

DATE SIGNED	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor.)
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I HAVE ATTACHED THE BELOW-LISTED DOCUMENTS FOR REVIEW BY THE RECOVERY JUDGE ADVOCATE ATTORNEY:

- ☐ **Traffic Accident Report**
- ☐ **Auto Accident Diagram**
- ☐ **Insurance Policy Copy**
- ☐ **Leave & Earning Statement (LES)**
- ☐ **Military Medical Record Copies**
- ☐ **Other Document(s)**